DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/16/17 / 70th 10/11/17

PRINTED: 08/03/2017
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445131 | A. BUILDING 01 - BUILDING A<br>B. WING | 07/31/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEVERLY PARK PLACE HEALTH AND REHAB | 5321 BEVERLY PARK CIRCLE<br>KNOXVILLE, TN 37918 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 000 | INITIAL COMMENTS<br><br>A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 7/31/17. During this life safety survey, Beverly Park Place Health and Rehabilitation was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | K-111<br><br>1.<br>On 08-02-17, Merit Construction Company was notified by the Maintenance Director of the need to repair the fire doors on the second and third floors in the area of the new construction and the unsealed penetrations on the third floor in the area of the new construction. The repairs will be completed by Merit Construction by 09-01-17.<br><br>2.<br>The Maintenance Director conducted a 100% audit of fire doors and fire walls on 08-01-17. No other areas were identified as being affected. | 9-01-17 |
| K 111<br>SS=D | NFPA 101 Building Rehabilitation<br><br>Building Rehabilitation<br>Repair, Renovation, Modification, or Reconstruction<br>Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following:<br>* Requirements of Chapter 18 and 19<br>* Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6<br>18.1.1.4.3, 19.1.1.4.3, 43.1.2.1<br>Change of Use or Change of Occupancy<br>Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2<br>18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)<br>Additions<br>Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming | K 111 | 3.<br>The Maintenance Director in-serviced the maintenance staff on 08-14-17 on proper fire door gaps and wall penetrations and to check outside vendors for proper work performed.<br><br>4.<br>A 100% audit will be completed monthly x3 and/or until 100% compliance by the Maintenance Director of fire doors and fire walls for proper gaps and penetrations.<br><br>Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Suzette Williamson | NHA | 8-21-17 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 111 | Continued From page 1<br>building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8.<br>18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)<br>This STANDARD is not met as evidenced by:<br>Based on observation, the facility failed to maintain fire doors and fire barrier walls in the 2 hour fire barrier for separation of a nonconforming building.<br><br>NFPA 101 2012 Ed. 19.1.3.5, 8.3.3.1<br>NFPA 80 2010 Ed. 6.3.1.7.1<br><br>This deficiency affects 2 of 19 smoke compartments.<br><br>The findings include:<br><br>Observation on 7/31/17 between 2:50 PM and 3:25 PM revealed the following:<br>1. Fire doors in the 2 hour fire barrier have a gap exceeding 3/16 inch at the meeting edges of the doors on the 2nd and 3rd floor connector of the nonconforming building.<br>2. Unsealed penetrations in the 2 hour fire barrier on the 3rd floor connector of the nonconforming building.<br><br>Maintenance was present when the deficiency was identified and acknowledged by the administrator during the exit conference on | K 111 | | |

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| K 111 | Continued From page 2<br>7/31/17. | K 111 | | |
| K 200 SS=F | NFPA 101 Means of Egress Requirements - Other<br><br>Means of Egress Requirements - Other<br>List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>18.2, 19.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation the facility failed to identify doors that are likely to be mistaken for an exit with No Exit signage.<br><br>NFPA 101 2012 Ed. 19.3.7.5.1, 7.10.8.3.1<br><br>This deficiency affects 4 of 19 smoke compartments<br><br>The findings include:<br><br>Observation on 7/31/17 at 3:40 PM revealed cross corridor doors leading into the crosswalk connectors on the main level, 1st, 2nd, and 3rd floor are not the means of egress for the nursing home and can be mistaken for an exit. These doors are not identified by a NO Exit sign.<br><br>Maintenance was present when the deficiency was identified and acknowledged by the administrator during the exit conference on | K 200 | K-200<br><br>1.<br>Proper signage was posted on the cross corridor doors on the first, second and third floors on 08-03-17 by the Maintenance Director. The Main floor does not require signage as the cross corridor door does lead to an exit.<br><br>2.<br>The Maintenance Director conducted a 100% audit on 08-01-17 for proper signage on doors. No other areas were identified as being affected.<br><br>3.<br>The Maintenance Director in-serviced the maintenance staff on 08-14-17 on signage placement and proper wording.<br><br>4.<br>Proper signage on doors will be audited monthly x3 and/or until 100% compliance by the Maintenance Director.<br><br>Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director | 9-01-17 |

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| K 200 | Continued From page 3<br>7/31/17. | K 200 | K-321 | |
| K 321 SS=E | NFPA 101 Hazardous Areas - Enclosure<br><br>Hazardous Areas - Enclosure<br>2012 EXISTING<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1<br><br>Area Automatic Sprinkler<br>Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms<br>(exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces<br>(over 50 square feet)<br>g. Laboratories (If classified as Severe Hazard - see K322)<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain hazardous areas - enclosures.<br>This deficiency affected 3 of 19 smoke compartments. | K 321 | 1.<br>The holes in the wall in the laundry chute collection room were repaired from 08-03-17 to 08-04-17 by maintenance staff. The repairs on the unsealed penetrations and "blow out patch" in the lower level mechanical room were initiated by maintenance staff on 08-15-17 and will be completed by 08-25-17. The repairs on the head of the wall, unsealed penetrations and "blow out patch" in the third floor mechanical room were initiated by maintenance staff on 08-15-17 and will be completed by 08-25-17.<br><br>2.<br>The Maintenance Director conducted a 100% audit of the laundry room and all mechanical rooms for wall repair and penetrations. No other areas were identified as being affected.<br><br>3.<br>The Maintenance Director in-serviced the maintenance staff on wall penetrations and repair on 08-14-17. | 9-01-17 |

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| K 321 | Continued From page 4<br><br>NFPA 101, 19.7.6<br>NFPA 101, 19.3.2.1<br><br>The findings include:<br><br>Based on observation and interview, the facility failed to maintain hazardous areas - enclosures in the following locations;<br><br>1. Lower level mechanical equipment room had multiple unsealed penetrations and an unapproved "blow out patch."<br>2. The lower level laundry chute collection room had several holes in the walls.<br>3. Third floor mechanical room head of wall was unsealed, unsealed penetrations and an unapproved "blow out patch."<br><br>The maintenance director was present when the deficiencies were identified and was acknowledged by the administrator during the exit conference on 7/31/17. | K 321 | 4.<br>The Maintenance Director will conduct an audit of the laundry and mechanical rooms for wall penetrations and repair monthly x3 and/or until 100% compliance.<br>Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director | 9-01-17 |
| K 372 SS=E | NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke | K 372 | | |

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| K 372 | Continued From page 5<br>barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This STANDARD is not met as evidenced by:<br>Based on observation, the facility failed to maintain smoke barrier walls.<br><br>NFPA 101 2012 Ed. 19.3.7.3<br><br>This deficiency affects 3 of 19 smoke compartments.<br><br>The findings include:<br><br>Observation on 7/31/17 between 3:00 PM and 3:30 PM revealed penetrations in smoke barriers in the following locations:<br>1. Above ceiling by room 301 in corridor, smoke barrier wall has 1 unsealed penetration and the head wall is not sealed.<br>2. Inside room 313, smoke barrier wall does not have approved fire stop system by mixed fire caulking.<br>3. Above ceiling by room 316 in corridor, has unsealed penetration, unapproved fire stop system by mixed fire caulk and the head wall is not sealed.<br><br>Maintenance was present when the deficiency was identified and acknowledged by the administrator during the exit conference on 7/31/17. | K 372 | K-372<br><br>9-01-17<br><br>1.<br>On 08-07-17, contact was made by the Maintenance Director to the 3M-fire caulk representative to obtain information on the correct fire caulk system to utilize. The information was emailed to the Maintenance Director by the 3M representative on 08-11-17. The Maintenance Director ordered the fire caulk on 08-17-17. The repairs to the smoke walls will be completed by maintenance staff by 09-01-17.<br><br>2.<br>The Maintenance Director conducted a 100% audit of smoke walls on 08-03-17. No other areas were identified as being affected.<br><br>3.<br>The Maintenance Director in-serviced the maintenance staff on different fire caulk systems and their uses on 08-14-17.<br><br>4.<br>The Maintenance Director will conduct an audit to ensure no wall penetrations are unsealed monthly x3 and/or until 100% compliance.<br><br>Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director. | |
| K 374 SS=E | NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Doors | K 374 | | |

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| K 374 | Continued From page 6<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>This STANDARD is not met as evidenced by:<br>Based on observation, the facility failed to maintain smoke barrier doors.<br><br>NFPA 101 2012 Ed. 19.3.7.6, 19.3.7.8, 19.3.7.9<br><br>This deficiency affects 4 of 19 smoke compartments.<br><br>The findings include:<br><br>Observation on 7/31/17 at 11:35 AM and 2:15 PM revealed smoke barrier doors in front of room 301 and room 201 failed to close completely to resist the passage of smoke.<br><br>This deficiency affects 3 of 19 smoke compartments. | K 374 | K-374<br><br>1.<br>The fire doors outside of rooms 201 and 301 were repaired and tested on 08-01-17 by maintenance staff.<br><br>2.<br>The Maintenance Director conducted a 100% audit of fire doors on 08-01-17. No other areas were identified as being affected.<br><br>3.<br>The Maintenance Director in-serviced the maintenance staff on fire door operations on 08-14-17.<br><br>4.<br>The fire doors will be audited for proper operation and closure by the Maintenance Director monthly x3 and/or until 100% compliance.<br><br>Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director | 9-01-17 |
| K 923 SS=E | NFPA 101 Gas Equipment - Cylinder and Container Storag<br><br>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and | K 923 | | |

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| K 923 | Continued From page 7<br>5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain oxygen storage areas. This deficiency affected 2 of 19 smoke compartments.<br><br>NFPA 101, 19.7.6<br>NFPA 99, 11.3.4.1 | K 923 | K-923<br>9-a-17<br><br>1.<br>Signage was ordered on 08-02-17 and installed on 08-07-17 by the Maintenance Director on the Main and Lower Level oxygen storage rooms.<br><br>2.<br>The Maintenance Director conducted a 100% audit for signage on oxygen storage rooms on 08-0[illegible]-17. No other areas were identified as being affected.<br><br>3.<br>The Maintenance Director in-serviced the maintenance staff on signage placement and proper wording on 08-14-17.<br><br>4.<br>Oxygen storage rooms will be audited monthly x 3 and/or until 100% compliance by the Maintenance Director for proper signage. | |

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| K 923 | Continued From page 8<br><br>The findings include:<br><br>Observation and interview with the maintenance director on 7/31/17 between 11:00 and 11:46 AM revealed the main oxygen storage room and oxygen storage on the ground floor were not provided with required signage.<br><br>The maintenance director was present when the deficiencies were identified and was acknowledged by the administrator during the exit conference on 7/31/17. | K 923 | Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director | 9-01-17 |